SPINE TRIAGE PHYSICIANS
& MULTIDISCIPLINARY SPINE CARE TEAM

Riley Park Village
200 – 1402 8th Avenue N.W.
Calgary, AB T2n 1B9

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Acknowledgement of Cancellation Policy

Following your assessment today you may choose to have follow-up appointments here at Caleo Health with the triage physician. It is the patient's responsibility to attend all appointments booked on their behalf or to provide at least *24 hours' notice for appointment cancellations.* If you cancel without due notice, we lose two patients – you and the person who would have been treated in that time slot.

Please Note: you are able to leave a message to cancel appointments during business hours and also on our after-hours voicemail. A Caleo Health receptionist will follow up with you within two (2) business days.

I acknowledge that if I do not provide at least *24 hours' notice for appointment cancellations* with the triage physician, I will be charged a Late Cancellation/No Show fee of a $50.00 for follow up appointments and $100.00 for initial assessment appointments.

I also acknowledge that third party funders may not pay for the late cancellation charges I may incur and that I may be personally responsible for paying any such charges. If I choose not to pay the late cancellation/no show fees incurred for missed appointments or I have more than two (2) late cancellations or no shows, I will automatically be discharged from the care of the physician and will require a new referral to Caleo Health to begin the process from step one.

By signing below, I hereby declare that I acknowledge and understand the terms and conditions herein and I have been given the opportunity to address any questions or concerns. I also understand that *I will be required to pay all outstanding fees prior to my next appointment.*

Caleo Health understands that circumstances arise that are outside of our control and emergencies happen. We only ask that if this is the case please notify us as soon as possible prior to your appointment time. These cases will be given special consideration. Thank You!

Patient Name *(Please Print)*: ____

Signature: ____ Date: _______________________

The same policy is in effect for patients that are No Shows for their appointments.

SPINE ASSESSMENT PAIN DIAGRAM

To be completed by the patient prior to the assessment

Date: ______________________

Patient Name: ______________________________________ **Gender:** ❑ Male ❑ Female **Dominant Hand:** ❑ Right ❑ Left

Do you have a pacemaker: ❑ No ❑ YES

Is there a chance that you may be pregnant: ❑ No ❑ YES ❑ N/A

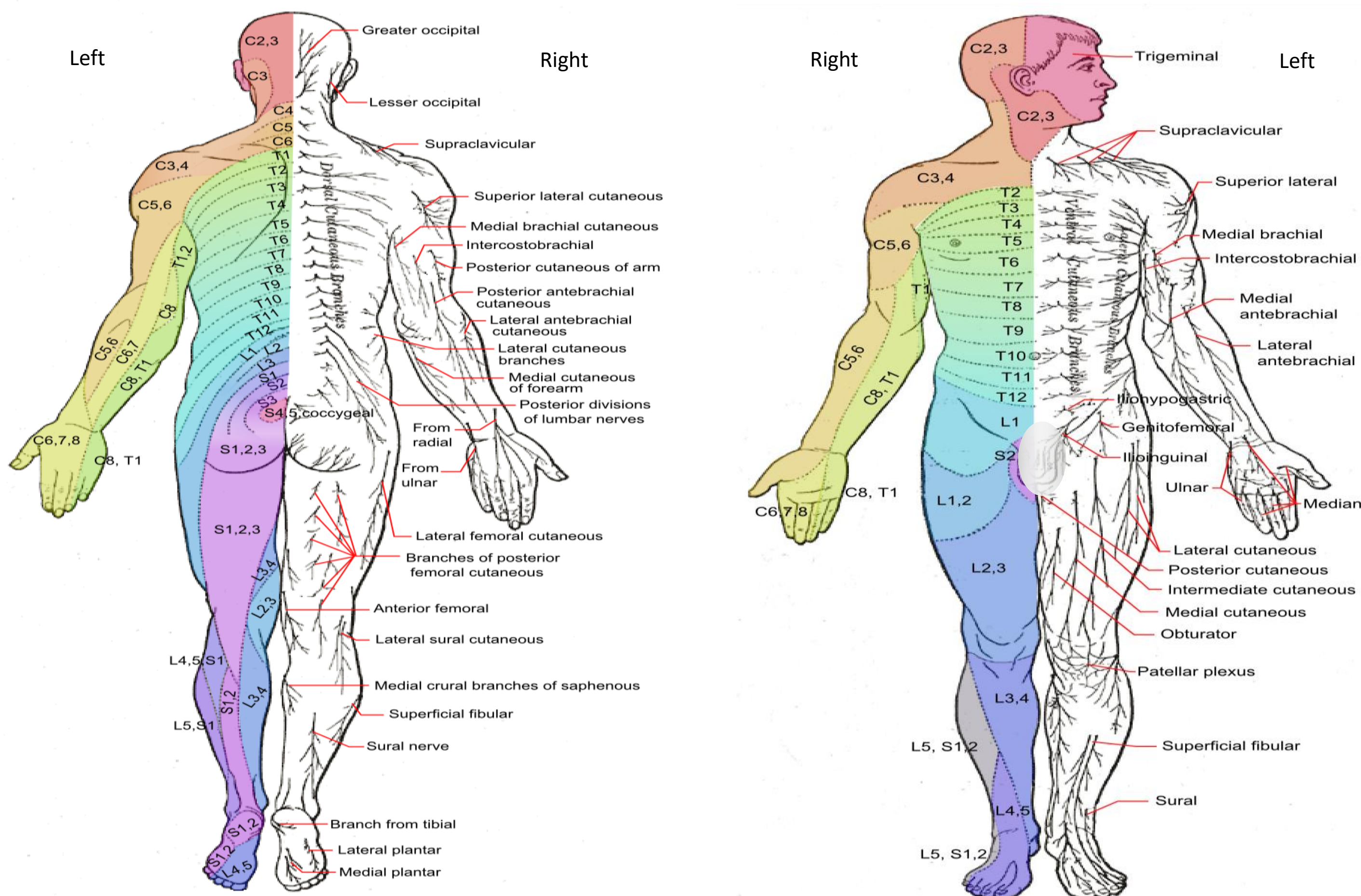
Area Affected: (*Select only one – the most severely affected area)*

❑ Neck ❑ Neck with arm pain ❑ Mid Back ❑ Low Back ❑ Low Back with leg pain ❑ Low Back/buttocks pain

Is your condition/injury due to one of the following?

❑ Motor Vehicle Accident (MVA) ❑ Workplace Injury (WCB) ❑ Personal Injury *(Slip & Fall)* Date of Injury: ___________

☞ Please CIRCLE the area on the diagram that corresponds to where you feel the pain or other symptoms.



Please describe the interval of your pain/symptoms by checking the appropriate box (select only one).

❑ Constant (pain/symptom is present all the time) ❑ Frequent (pain/symptom is present most of the time)

❑ Occasional (pain/symptom is present sometimes) ❑ Intermittent (pain/symptom comes and goes)

How would you describe the pain/symptom(s) you experience <u>the most</u>? (Select only one)

❑ Achy/Dull ❑ Sharp/Stabbing ❑ Numbness ❑ Burning ❑ Stiffness ❑ Pins & Needles ❑ Other __________

☞ Please rate your **current pain** on a scale from 0 to 10 (0 = No pain, 10 = Unbearable pain): Enter Number here ______________ / 10

Since the start of this condition, it is: ❑ Getting Better ❑ Getting Worse ❑ Unchanged

Currently would you say your health is: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

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Spinal Triage Assessment

Please print clearly or type.

Client's Surname	First Name		Initial	Date of Birth *(dd/mm/yyyy)*
Address	City/Town	Province	Postal Code	Telephone Number ( )
WCB Claim Number: (if applicable)				

I acknowledge that:

1. The Spinal Triage Assessments (the "Assessment") is not approved by WCB as medical aid under the Workers' Compensation Act as the WCB has other processes in place to determine what is medically indicated in spinal cases.
2. Any fee, as a balance billing or otherwise, payable to Caleo Health or any third party in relation to an Assessment shall not be payable by the WCB.
3. The WCB shall not reimburse me or any other person for any fee paid or payable for an Assessment.

Client's Signature: ____

Representative for Caleo Health, Signature or Stamp: ____________________________

Date: ______________________